

APPENDIX A

Technical Unit - List of Classes

Aircraft Pilot-E	E12
Aircraft Pilot-A	13
Aviation Electronics Technician –E	9
Aviation Electronics Technician-E	10
Aviation Electronics Technician-E	E11
Aviation Electronics Technician-A	12
Dental Hygienist	E11
Dental Lab Technician-E	8
Dental Lab Technician-E	9
Dental Lab Technician-E	E10
Dental Lab Technician-A	11
Dental Lab Technician-SS	12
Drafting Technician-E	8
Drafting Technician-E	9
Drafting Technician-E	E10
Drafting Technician-A	11
Drafting Technician-SS	12
Engineering Assistant-E	6
Engineering Assistant-E	7
Engineering Assistant-E	E8
Engineering Assistant-A	9
Engineering Technician-E	8
Engineering Technician-E	9
Engineering Technician-E	E10

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Engineering Technician-A	11
Engineering Technician-SS	12
Environmental Technician-E	8
Environmental Technician-E	9
Environmental Technician-E	E10
Environmental Technician-A	11
Environmental Technician-SS	12
Equipment Technician-E	8
Equipment Technician-E	9
Equipment Technician-E	E10
Equipment Technician-A	11
Equipment Technician-SS	12
Fingerprint Technician-E	7
Fingerprint Technician-E	8
Fingerprint Technician-E	E9
Fingerprint Technician-A	10
Fisheries Assistant-E	6
Fisheries Assistant-E	E7
Fisheries Assistant-A	8
Fisheries Technician-E	8
Fisheries Technician-E	9
Fisheries Technician-E	E10
Fisheries Technician-A	11
Fisheries Technician-SS	12
Forensic Technician-E	8
Forensic Technician-E	9
Forensic Technician-E	E10

Forensic Technician-A	11
Forensic Technician-SS	12
Forest Technician-E	8
Forest Technician-E	9
Forest Technician-E	E10
Forest Technician-A	11
Geological Technician-E	8
Geological Technician-E	9
Geological Technician-E	E10
Geological Technician-A	11
Geological Technician-SS	12
Graphic Arts Designer-E	9
Graphic Arts Designer-E	10
Graphic Arts Designer-E	E11
Graphic Arts Designer-A	12
Graphic Arts Designer-SS	13
Laboratory Assistant-E	6
Laboratory Assistant-E	7
Laboratory Assistant-E	E8
Laboratory Assistant-A	9
Laboratory Glassware Worker-E	4
Laboratory Glassware Worker-E	E5
Laboratory Glassware Worker-A	6
Laboratory Technician-E	8
Laboratory Technician-E	9
Laboratory Technician-E	E10
Laboratory Technician-A	11

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Laboratory Technician-SS	12
Media Production Specialist-E	9
Media Production Specialist-E	10
*Media Production Specialist-E	P11
Pharmacy Assistant-E	E8
Photographer-E	9
Photographer-E	10
Photographer-E	E11
Photographer-A	12
Photo Services Assistant-E	6
Photo Services Assistant-E	7
Photo Services Assistant-E	E8
Photo Services Assistant-A	9
Radio Communications Technician-E	8
Radio Communications Technician-E	9
Radio Communications Technician-E	E10
Radio Communications Technician-A	11
Radio Communications Technician-SS	12
Respiratory Therapy Technician-E	8
Respiratory Therapy Technician-E	9
Respiratory Therapy Technician-E	E10
*State Worker	4
*Student Assistant-E	A
Surveying Technician-E	8
Surveying Technician-E	9
Surveying Technician-E	E10
Surveying Technician-A	11

Transportation Aide	6
Transportation Aide	E7
Transportation Technician-A	11
Transportation Technician-E	8
Transportation Technician-E	9
Transportation Technician-E	E10
Transportation Technician-SS	12
Veterinary Technician-E	8
Veterinary Technician-E	9
Veterinary Technician-E	E10
Veterinary Technician-A	11
Water Quality Technician-E	8
Water Quality Technician-E	9
Water Quality Technician-E	E10
Water Quality Technician-A	11
Water Quality Technician-SS	12
Wildlife Technician-E	8
Wildlife Technician-E	9
Wildlife Technician-E	E10
Wildlife Technician-A	11
Wildlife Technician-SS	12
X-Ray Technician-E	8
X-Ray Technician-E	9
X-Ray Technician-E	E10
X-Ray Technician-A	11

*Some employees in these classes may be included and others excluded (and assigned a different, excluded unit code) depending on specific duties of the position.

APPENDIX D

Departmental Layoff Units and Bumping Sequence

1. Departmental Layoff Units

In accordance with the provisions of Article 13 of this Agreement, the following represents the designated layoff units for Department/Agencies which employ members of this Unit unless altered through secondary negotiations.

A. Department of Transportation:

region, except for the Lansing area which will include the Secondary Complex and the Bureau of Aeronautics as one layoff unit.

B. Department of Natural Resources:

County

C. Department of Agriculture and Rural Development/Department of Environmental Quality:

County

D. Departments of State Police/Technology, Management and Budget:

County, except that Ingham and Eaton shall be one layoff unit.

E. Department of Community Health:

County

F. In the following Departments, layoff units shall be the geographical or organizational entity as defined in the employment preference plans on file with Civil Service unless altered through secondary negotiations.

Civil Service unless altered through secondary negotiations.

Department of Corrections

Department of Civil Service

Department of Education

Unemployment Insurance Agency

Department of Military and Veterans Affairs

Department of State

Department of Licensing and Regulatory Affairs

Department of Treasury

Department of Human Services

2. Bumping Procedure

Employees of this Unit, if exercising their option to bump, shall do so in the sequence provided herein unless altered through secondary negotiations.

A. Department of Transportation/Technology, Management and Budget:

- (1) The employee shall have the right to first bump laterally within his/her current class/level in his/her layoff unit.
- (2) If a lateral bump as provided in A1 above is unavailable, the employee may bump at the next and successively lower levels within his/her current class series within his/her layoff unit if available. If not, the employee may bump at the next and successively lower levels statewide.

B. Departments of Agriculture and Rural Development/State Police/Environmental Quality/Community Health/Natural Resources:

- (1) The employee shall have the right to first bump laterally in his/her current class/level within his/her layoff unit.
- (2) If a lateral bump as provided in B1 above is unavailable, the employee shall have the option of bumping at the next and successively lower levels within his/her current class series within the layoff unit.
- (3) If a bump, as provided in B2 above is unavailable the employee may bump in his/her class/level statewide. If this is unavailable, the employee may bump at successively lower levels within his/her current class series statewide.

C. The bumping procedure for those Departments designated in Section 1(f) of this Appendix shall be in accordance with the employment preference plans on file with Civil Service unless altered through secondary negotiations.

3. The parties agree that an employee's bumping rights as provided in Section 2A-C above, shall only be exercised in the Bargaining Unit and only in those classifications to which the employee has served and attained Civil Service status.

APPENDIX E

Reassignment Expense Reimbursement for Eligible Employees

1. Persons Covered:

All authorized full-time employees currently employed by the State of Michigan being reassigned under Article 16, who actually move their residence closer to the new work location as a direct result of the reassignment, and who agree to continue employment in the new location for a minimum of one year are entitled to all benefits provided by this Appendix and as provided under the State of Michigan, Administrative Guide to State Government, 0430.01, Payment of Household Moving Expenses. New employees not presently (on the effective date of this Agreement) working for the State of Michigan shall not be entitled to benefits provided in this Appendix.

2. By Commercial Mover:

The State will pay the transportation charges for normal household goods up to a maximum of 14,000 pounds for each move. Charges for weight in excess of 14,000 pounds must be paid directly to the mover by the employee.

- A. Household Goods: Includes all furniture, personal effects and property used in a dwelling, and normal equipment and supplies used to maintain the dwelling except automobiles, boats, camping vehicles, firewood, fence posts, toolsheds, motorcycles, snowmobiles, explosives, or property liable to impregnate or otherwise damage the mover's equipment perishable foodstuffs subject to spoilage, building materials, fuel or other similar non-household good items.
- B. Packing: The State will pay up to \$800 for packing and/or unpacking breakables. The employee must make arrangements and pay the mover for any additional packing required.
- C. Insurance: The carrier will provide insurance against damage up to \$.60 per pound for the total weight of shipment. The State will reimburse the employee for insurance cost not to exceed an additional \$.65 per pound for the total weight of the shipment.

In addition to the above packing allowances:

The State will pay the following accessorial charges which are required to facilitate the move.

- A. Appliance Service;
- B. Piano or organ handling charges;
- C. Flight, elevator or distance carry charges;

- D. Extra labor charges required to handle heavy items, i.e., pianos, organs, freezers, pool tables, etc.

Charges for stopping in transit to load or unload goods and the cost of additional mileage involved to effect a stop in transit must be paid by the employee. Also, extra labor required to expedite a shipment at the request of the employee must be paid by the employee.

3. Mobile Homes:

The State will pay the reasonable actual cost for moving a mobile home if it is the employee's domicile, plus a maximum \$1,000 allowance for blocking, unblocking, securing contents or expando units, installing or removal of tires (on wheels) on or off the trailer, AND removal or replacement of skirting will be paid by the State when accompanied by receipts.

Utility connections to existing utilities within an established mobile home park, up to \$200, when accompanied by receipts. ("utility connections" means connecting to existing electrical power, gas and water.)

"Actual moving cost" includes only the transportation cost, escort service when required by the governmental unit, special lighting permits, tolls or surcharges. "Actual moving cost" does not include the moving of oil tanks, out buildings, swingsets, etc. that cannot be dismantled and secured inside the mobile home.

Mobile home liability is limited to damage to the unit caused by negligence of the carrier, and to contents up to a value of \$1,500. Additional excess valuation and/or hazard insurance may be purchased from the carrier at the expense of the employee.

The repair or replacement of equipment of the trailer, i.e., tires, axles, bearings, lights, etc. are the responsibility of the owner.

4. Storage of Household Goods:

The State will pay for storage not in excess of sixty (60) calendar days in connection with an authorized move at either origin or destination, only when housing is not readily available.

5. Temporary Travel Expense:

From effective date of reassignment, up to sixty (60) calendar days of travel expenses at the newly assigned work station are allowed. Extension beyond sixty days, but not to exceed a total of one hundred eighty (180) days, may be allowed due to unusual circumstances at the full discretion of the Employer. Authorized travel shall include one (1) round trip weekly between the new work station and the former residence.

6. To Secure Housing:

A continuing employee and one (1) additional family member will be allowed up to three (3) round trips to a new official work station for the purpose of securing housing. Travel, lodging, and food costs will be reimbursed up to a maximum of nine (9) days in accordance with the Standardized Travel Regulations.

APPENDIX F

Letter of Understanding—Article 26

The attached Rules for Network Use will be used by the parties in determining in-network and out-of-network benefits. In addition, the parties agree to set up a joint committee for the purpose of creating any additional guidelines and reviewing implementation. The committee will also be charged with identifying situations in which access to non-participating providers may be necessary and developing procedures to avoid balance billing in these situations.

The parties have also discussed the fact that there are some State employees who do not live in Michigan. The following are procedures in place for persons living or traveling outside Michigan:

Members who need medical care when away from Michigan can take advantage of the Third Party Administrator's National PPO program. There is a toll-free number for members to call in order to be directed to the nearest PPO provider. The member is not required to pay the physician or hospital at the time of service if he/she presents the PPO identification card to the network provider.

If a member is traveling he/she must seek services from a PPO provider. Failure to seek such services from a PPO provider will result in a member being treated as out-of-network unless the member was seeking services as the result of an emergency.

If a member resides out of state and seeks non-emergency services from a non-PPO provider, he/she will be treated as out-of-network. If there is not adequate access to a PPO provider, exceptions will be handled on a per case basis.

RULES FOR NETWORK USE

Effective October 12, 2014, see Appendix G-2 for member costs.

A member is considered to have access to the network based on the type of services required, if there are:

- Primary care -two primary care physicians (PCP) within 15 miles;
- Specialty care -two specialty care physicians (SCP) within 20 miles; and
- Hospital - one hospital within 25 miles.

The distance between the member and provider is the center-point of one zip code to the center-point of the other.

SHP PPO MEMBER COSTS ASSOCIATED WITHIN IN-NETWORK OR OUT-OF-NETWORK USE (for eligible employees hired prior to April 1, 2010 and covered by the SHP PPO)

	IN-NETWORK	OUT-OF-NETWORK
Deductible	\$200/Individual	\$500/Individual
	\$400/Family	\$1,000/Family
Effective 1-1-09	\$300/Individual	\$600/Individual
	\$600/Family	\$1,200/Family
Co-Payments	Office Visits \$10	Most Services 10%
Effective 10-1-08	Office Visits \$15	
	Services 0% Or 10%	(See 2. Below)
	Emergency 0%	
Effective 10-1-08	Emergency room visit	Emergency room visit
	\$50 co-pay if not admitted	\$50 co-pay if not admitted
Preventive Services	Covered At 100%	Not Covered
	Limited To \$1500 Per Calendar Year Per Person.	
Out-of-Pocket	\$1,000/Individual	\$2,000/Individual
Maximum	\$2,000/Family	\$4,000/Family

NSHP PPO MEMBER COSTS ASSOCIATED WITHIN IN-NETWORK OR OUT-OF-NETWORK USE (for eligible employees hired on or after April 1, 2010 and covered by the NSHP PPO)

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	In-Network	Out-of-Network
Deductible	\$400/individual \$800/family	\$800/individual \$1,600/family
Copayments	Office Visits \$20 Services 0% or 10% Emergency \$200 co-pay if not admitted	Most services 20%
Preventive Services	Covered at 100%	Not covered
Out-of-Pocket Maximum	\$1,500/individual \$3,000/family	\$3,000/individual \$6,000/family

1. If a member has access to the network, the member receives benefits at the in-network level when a network provider is used. The member is responsible for the in-network deductible (if any) and co-payment (if any). If a network provider refers the member to an out-of-network SCP the member continues to pay in-network expenses.
2. If a member has access to the network, the member receives benefits at the out-of-network level when a non-network provider is used. The member is responsible for the out-of-network deductible (if any), and co-payment (if any).
 - If the non-network provider is a Blues' participating provider, the provider will accept the Blues' payment as payment in full. The member is responsible for the out-of-network deductible and co-payment. The member will not, however, be balance billed.
 - If the non-network provider is not a Blues' participating provider, the provider does not accept blues' payment as payment in full. The member is responsible for the out-of-network deductible and co-payment. The member may also be balance billed by the provider for all amounts in excess of the Blues' approved payment amount.

When a member has access to the network and chooses to use an out-of-network provider, amounts paid toward the out-of-network deductible, co-

payment or out-of-pocket maximum cannot be used to satisfy the in-network deductible, co-payments or out-of-pocket maximum.

3. If a member does not have access to the network as provided above, the member will be treated as in-network for all benefits. The member will be responsible for the in-network deductible (if any) and co-payment (if any).
4. If a member does not have access to the network but then additional providers join the network so that the member would now be considered in-network, the member will be notified and given a reasonable amount of time in which to seek care from an in-network provider. Care received from a non-network provider after that grace period will be considered out-of-network and the out-of-network deductibles, co-payments and out-of-pocket maximums will apply. If a member is undergoing a course of treatment at the time he becomes in-network, the in-network rules will continue for that course of treatment only pursuant to the PPO standard transition policy. Once the course of treatment has been finished, the member must use an in-network provider or be governed by the out-of-network rules.

If a member is under a course of treatment on January 1, 2003 when the new State Health Plan is implemented, the member will be treated as in-network until the course of treatment is concluded pursuant to the PPO standard transition policy. After that, the level of benefits will be governed by the in/out-of-network rules of the new State Health Plan.

APPENDIX G

Article 26—State Health Plan PPO – Benefit Chart

Appendix G remains in effect for eligible employees hired prior to April 1, 2010 and covered by the State Health Plan PPO.

State Health Plan (PPO)		
	In-Network	Out-of-Network
Preventive Services - Limited to \$1500 per calendar year per person		
Health Maintenance Exam – includes chest X-ray, EKG and select lab procedures	Covered –100%, one per calendar year	Not covered
Annual Gynecological Exam	Covered –100%, one per calendar year	Not covered
Pap Smear Screening-laboratory services only	Covered –100%, one per calendar year	Not covered

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Well-Baby and Child Care	Covered –100% - 6 visits per year through age 1 - 2 visits per year, age 2 through 3 - 1 visit per year, age 4 through 15	Not covered
Immunizations (no age limit). Annual flu shot; Hepatitis C screening covered for those at risk	Covered – 100%	Not covered
Fecal Occult Blood Screening	Covered –100%, one per calendar year	Not covered
Flexible Sigmoidoscopy Exam Colonoscopy Exam	Covered – 100%	Not covered
Prostate Specific Antigen (PSA) Screening	Covered – 100%, one per calendar year	Not covered
PREVENTIVE SERVICES NOT SUBJECT TO MAXIMUM LIMIT		
Mammography Screening for standard film. Covers digital up to standard film rate	Covered – 100%	Covered - 90% after deductible
	One per calendar year, no age restrictions	
Colonoscopy Exam (Effective Jan. 1, 2006)	Covered – 100%	Covered - 90% after deductible
	Beginning At Age 50; One Every 10 Years	
Childhood Immunizations (Effective Jan. 1, 2006)	Covered 100% For Children Through Age 16	Covered 90% After Deductible
Physician Office Services		
Office Visits Effective 10-1-08:	Covered - \$10 co-pay Covered - \$15 co-pay	Covered - 90% after deductible, must be medically necessary
Outpatient and Home Visits	Covered – 100% after deductible	Covered - 90% after deductible, must be medically necessary
Office Consultations Effective 10-1-08:	Covered - \$10 co-pay Covered - \$15 co-pay	Covered - 90% after deductible,

		must be medically necessary
Emergency Medical Care		
Hospital Emergency Room-approved diagnosis, prudent person rule	Covered - 100% for emergency medical illness or accidental injury	Covered - 100% for emergency medical illness or accidental injury
Effective 10-1-08:	Covered - 100%, after a \$50 co-pay if not admitted, for emergency medical illness or accidental injury	Covered - 100%, after a \$50 co-pay if not admitted, for emergency medical illness or accidental injury
Ambulance Services – medically necessary for illness and injury	Covered – 100% after deductible	Covered - 100% after deductible
Diagnostic Services		
Laboratory and Pathology Tests	Covered – 100% after deductible	Covered - 90% after deductible
Diagnostic Tests and X-rays	Covered – 100% after deductible	Covered - 90% after deductible
Radiation Therapy	Covered – 100% after deductible	Covered - 90% after deductible
Maternity Services Provided by a Physician		
Pre-Natal and Post-Natal Care	Covered - 100% after deductible	Covered - 90% after deductible
	Includes care provided by a Certified Nurse Midwife	
Delivery and Nursery Care	Covered - 100% after deductible	Covered - 90% after deductible
	Includes delivery provided by a Certified Nurse Midwife	
Hospital Care		
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies, and Blood Storage	Covered - 100% after deductible Unlimited Days	Covered - 90% after deductible Unlimited Days

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Inpatient Consultations	Covered - 100% after deductible	Covered - 90% after deductible
Chemotherapy	Covered - 100% after deductible	Covered - 90% after deductible
Alternatives to Hospital Care		
Skilled Nursing Care	Covered - 100% after deductible	Covered – 90% after deductible
	120 days per confinement	
Hospice Care	Covered - 100%	Covered - 100%
	Limited to the lifetime dollar max. which is adjusted annually by the state	
Home Health Care	Covered - 100% after deductible	Covered - 100% after deductible
	Unlimited visits	
Surgical Services		
Surgery - includes related surgical services	Covered - 100% after deductible	Covered - 90% after deductible
Voluntary Sterilization	Covered - 100% after deductible	Covered - 90% after deductible
Human Organ Transplants		
Specified Organ Transplants - in designated facilities only - when coordinated through the TPA	Covered - 100% after deductible-in designated facilities only	Covered -100% after deductible in designated facilities only
	Up to \$1 million maximum per transplant type	
Bone Marrow - when coordinated through the TPA - specific criteria applies	Covered - 100% after deductible	Covered - 90% after deductible
Kidney, Cornea and Skin	Covered - 100% after deductible	Covered - 90% after deductible

Mental Health Care and Substance Abuse - Covered under non-BCBSM contract		
Inpatient Mental Health	100% up to 365 days per year. Partial Day Hospitalization at 2:1 ratio	50%, up to 365 days per year
Outpatient Mental Health Care	90% of network rates	50% of network rates
Inpatient Alcohol & Chemical Abuse Care	100% up to two 28-day admissions per calendar year, with 60 day interval. Intensive Outpatient Treatment at 2:1 ratio. Halfway House 100%	50% up to two 28-day admissions per calendar year, with 60 day interval. Intensive Outpatient Treatment at 2:1 ratio. Halfway House 50%
Outpatient Alcohol & Chemical Abuse	90% of network rates; Limit \$3,500/year chemical dependency only	50% of network rates Limit \$3,500/year chemical dependency only
Other Services		
Allergy Testing and Therapy	Covered - 100% after deductible	Covered - 90% after deductible
Rabies treatment after initial emergency room treatment	Covered - 100% after deductible	Covered - 90% after deductible
Chiropractic Spinal Manipulation	Covered - \$10 co-pay Covered - \$15 co-pay	Covered - 90% after deductible
Effective 10-1-08:		
	Up to 24 visits per calendar year	
Outpatient Physical, Speech and Occupational Therapy		
- Facility and Clinic	Covered - 100% after deductible	Covered - 100% after deductible
- Physician's Office - excludes speech and occupational therapy	Covered - 100% after deductible	Covered - 90% after deductible
	Up to a combined maximum of 90 visits per calendar year	

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Durable Medical Equipment	Covered 100%	Covered 80% Of Approved Charges
Prosthetic and Orthotic Appliances	Covered 100%	Covered 80% Of Approved Charges
Private Duty Nursing	Covered - 90% after deductible	Covered - 90% after deductible
Prescription Drugs	Covered under non-BCBSM contract	Covered under non-BCBSM contract
Hearing Care Program Effective 10-1-08:	\$10 office visits; more frequent than 36 months if standards met. \$15 office visits; more frequent than 36 months if standards are met.	
Acupuncture Therapy Benefit – Under the supervision of a MD/DO	Covered - 90% after deductible (up to 20 visits annually)	Covered - 90% after deductible (up to 20 visits annually)
Weight Loss Benefit	Upon meeting conditions, eligible for a lifetime maximum reimbursement of \$300 for non-medical, weight reduction.	
Wig, wig stand, adhesives	Upon meeting medical conditions, eligible for a lifetime maximum reimbursement of \$300. (Additional wigs covered for children due to growth.)	
Deductible, Co-pays and Dollar Maximums		
Deductible Effective 1-1-09:	\$200 per member; \$400 per family \$300per member; \$600per family	\$500 per member; \$1,000 per family \$600per member; \$1,200per family
Co-pays		
Fixed Dollar Co-pays - Do not apply toward deductible Effective 10-1-08:	\$10 for office visits/consultations, Chiropractic \$15 for office visits/consultations, Chiropractic	
- Percent Co-pays - MH/SA co-pays do not apply toward deductible - Services without a network are covered at the in-network level	10% for MHSA outpatient, and private duty nursing	10% for most services; MHSA at 50%
Annual Dollar Maximums		

- Fixed Dollar Co-pays - Do not apply toward out-of-pocket maximum	N/A	None
- Percent Co-pays - MH/SA and private duty nursing co-pays do not apply toward out-of-pocket maximum	\$1,000 per member; \$2,000 per family	\$2,000 per member; \$4,000 per family
Dollar Maximums	\$5 million lifetime per member for all covered services and as noted above for individual services	

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APPENDIX G-1

Appendix G-1 remains in effect for eligible employees hired on or after April 1, 2010 and covered by the New State Health Plan PPO or New HMO Plan.

Preventive Services

	New State Health Plan PPO “NSHP – PPO” Benefits		New HMO Plan “NHMO” Benefits
	In-network	Out-of-network	
Health maintenance exam	Covered 100% 1 per year	Not Covered	Covered 100% after \$20 office visit co-payment
Annual gynecological exam	Covered 100% 1 per calendar year	Not Covered	Covered 100% after \$20 office visit co-payment
Pap smear screening – laboratory services only ¹	Covered 100% 1 per year	Not Covered	Covered 100% after \$20 office visit co-payment
Well-baby and child care	Covered 100%	Not Covered	Covered 100% after \$20 office visit co-payment
Immunizations, annual flu shot & Hepatitis C screening for those at risk	Covered 100%	Not Covered	Covered 100% after \$20 office visit co-payment
Childhood Immunizations	Covered 100% through age 16	Covered 80%	Covered 100%
Fecal occult blood screening ¹	Covered 100%	Not Covered	Covered 100% after \$20 office visit co-payment
Flexible sigmoidoscopy ¹	Covered 100%	Not Covered	Covered 100% after \$20 office visit co-payment

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Prostate specific antigen screening ¹	Covered 100% one per year	Not Covered	Covered 100% after \$20 office visit co-payment
Mammography, annual standard film mammography screening (covers digital mammography up to the standard film rate) ¹	Covered 100%	Covered 80% after deductible	Check with HMO
Colonoscopy ¹	Covered 100%	Covered 80% after deductible	Covered 100% after \$20 office visit co-payment

¹ American Cancer Society guidelines apply

Physician Office Services

	New State Health Plan PPO “NSHP – PPO” Benefits		New HMO Plan “NHMO” Benefits
	In-network	Out-of-network	
Office visits, consultations and urgent care visits	Covered, \$20 co-pay, deductible not applicable	Covered 80% after deductible	\$20 co-pay
Outpatient and home visits	Covered 90% after deductible	Covered 80% after deductible	\$20 co-pay

Emergency Medical Care

	New State Health Plan PPO “NSHP – PPO” Benefits		New HMO Plan “NHMO” Benefits
	In-network	Out-of-network	
Hospital emergency room for medical emergency or accidental injury	\$200 co-pay if not admitted		\$200 co-pay if not admitted
Ambulance services – medically necessary	Covered 90% after deductible		Covered 100%

Diagnostic Services

	New State Health Plan PPO “NSHP – PPO” Benefits		New HMO Plan “NHMO” Benefits
	In-network	Out-of-network	
Laboratory and pathology tests	Covered 90% after deductible	Covered 80% after deductible	Covered 100%

Diagnostic tests and x-rays	Covered 90% after deductible	Covered 80% after deductible	Covered 100%
Radiation therapy	Covered 90% after deductible	Covered 80% after deductible	Covered 100%

Maternity Services

Includes care by a certified nurse midwife (New State Health Plan PPO only)

	New State Health Plan PPO “NSHP – PPO” Benefits		New HMO Plan “NHMO” Benefits
	In-network	Out-of-network	
Prenatal and postnatal care	Covered 90% after deductible	Covered 80% after deductible	Office Visit \$20 co-pay
Delivery and nursery care	Covered 90% after deductible	Covered 80% after deductible	Covered 100%

Hospital Care

	New State Health Plan PPO “NSHP – PPO” Benefits		New HMO Plan “NHMO” Benefits
	In-network	Out-of-network	
Semi-private room, inpatient physician care, general nursing care, hospital services and supplies	Covered 90% after deductible, unlimited days	Covered 80% after deductible, unlimited days	Covered 100% Unlimited days
Inpatient consultations	Covered 90% after deductible	Covered 80% after deductible	Covered 100%
Chemotherapy	Covered 90% after deductible	Covered 80% after deductible	Covered 100%

Alternatives to Hospital Care

	New State Health Plan PPO “NSHP – PPO” Benefits		New HMO Plan “NHMO” Benefits
	In-network	Out-of-network	
Skilled nursing care up to 120 days per confinement	Covered 90% after deductible		Covered 100%

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Hospice care	Covered 100% Limited to the lifetime dollar maximum that is adjusted annually by the State	Covered 100%
Home health care	Covered 90% after deductible, unlimited visits	Check with your HMO

Surgical Services

	New State Health Plan PPO “NSHP – PPO” Benefits		New HMO Plan “NHMO” Benefits
	In-network	Out-of-network	
Surgery—includes related surgical services.	Covered 90% after deductible	Covered 80% after deductible	Covered 100%
Voluntary sterilization	Covered 90% after deductible	Covered 80% after deductible	Check with your HMO

Human Organ Transplants

	New State Health Plan PPO “NSHP – PPO” Benefits		New HMO Plan “NHMO” Benefits
	In-network	Out-of-network	
Liver, heart, lung, pancreas, and other specified organ transplants	Covered 100% In designated facilities only. Up to \$1 million lifetime maximum for each organ transplant		Covered 100% in designated facilities

Organ and Tissue Transplants

	New State Health Plan PPO “NSHP – PPO” Benefits		New HMO Plan “NHMO” Benefits
	In-network	Out-of-network	
Bone marrow—specific criteria apply	Covered 100% after deductible in designated facilities		Covered 100% in designated facilities
Kidney, cornea, and skin	Covered 90% after deductible in designated facilities	Covered 80% after deductible	Covered 100% subject to medical criteria

Other Services

	New State Health Plan PPO “NSHP – PPO” Benefits		New HMO Plan “NHMO” Benefits
	In-network	Out-of-network	
Allergy testing and injections	Covered 90% after deductible	Covered 80% after deductible	Office visits: \$20 co-pay Injections: Covered 100%
Acupuncture	Covered 80% after deductible if performed by or under the supervision of a M.D. or D.O.		Check with your HMO
Rabies treatment after initial emergency room visit	Covered 90% after deductible	Covered 80% after deductible	Office visits: \$20 co-pay Injections: Covered 100%
Chiropractic/spinal manipulation	\$20 co-pay Up to 24 visits per calendar year	Covered 80% after deductible Up to 24 visits per calendar year	Check with your HMO

Other Services continued...

	New State Health Plan PPO “NSHP – PPO” Benefits		New HMO Plan “NHMO” Benefits
	In-network	Out-of-network	
Durable medical equipment -Support Program	Covered 100%	Covered 80% of approved amount	Covered
Prosthetic and orthotic appliances -Support Program	Covered 100%	Covered 80% of approved amount	Covered
Private duty nursing	Covered 80% after deductible		Covered
Wig, wig stand, Adhesives	Upon meeting medical conditions, eligible for a lifetime maximum reimbursement of \$300. (Additional wigs covered for children due to growth).		Check with your HMO
Hearing Care Exam	\$20 co-pay for office visit	Covered 80% after deductible	Check with your HMO

Mental Health/Substance Abuse

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	New State Health Plan PPO “NSHP – PPO” Benefits		New HMO Plan “NHMO” Benefits
	In-network	Out-of-network	
Mental Health Benefits -Inpatient	Covered 100% up to 365 days per year ²	Covered 50% up to 365 days per year	Check with your HMO
Mental Health Benefits - Outpatient	As necessary 90% of network rates 10% co-pay	As necessary 50% of network rates	Check with your HMO
Alcohol & Chemical Dependency Benefits -Inpatient	Covered ³ 100% Halfway House 100%	Covered 50% ⁴ Halfway House 50%	Check with your HMO
Alcohol & Chemical Dependency Benefits -Outpatient	\$3,500 per calendar year 90% of network rates 10% co-pay ⁴	\$3,500 per calendar year 50% of network rates	Check with your HMO

² Inpatient days may be utilized for partial day hospitalization (PHP) at 2:1 ratio. One inpatient day equals two PHP days.

³ Up to two 28-day admissions per year. There must be at least 60 days between admissions. Inpatient days may be utilized for intensive outpatient treatment (IOP) at 2:1 ratio. One inpatient day equals two IOP days.

⁴ \$3,500 per calendar year limitation pertains to services for chemical dependency only.

Prescription Drugs

Prescription medications for the New State Health Plan PPO are covered under the Participating Pharmacy ID Card Plan administered by BCBSM.

Prescriptions filled at a participating pharmacy may only be approved for up to a 34-day supply. Employees can still receive a 90-day supply by mail order.

To check the co-pay for drugs you may be taking, visit BCBSM website at <http://www.bcbsm.com/som> or contact BCBSM at (800) 843-4876. The Preferred/Non-preferred list of drugs is updated periodically as new drugs are added.

The chart below shows the NSHP and NHMO prescription drug member co-pays:

Generic	Brand Name Preferred	Brand Name Non-Preferred
Retail \$10	Retail \$30	Retail \$60
Mail Order \$20	Mail Order \$60	Mail Order \$120

Outpatient Physical, Speech, and Occupational Therapy

Combined maximum of 90 visits per calendar year.

	New State Health Plan PPO “NSHP – PPO” Benefits		New HMO Plan “NHMO” Benefits
	In-network	Out-of-network	
Outpatient physical, speech and occupational therapy – facility and clinic services	Covered 90% after deductible	Covered 90% after deductible	Office visit: \$20 co-pay
Outpatient physical therapy – physician’s office	Covered 90% after deductible	Covered 80% after deductible	Office visit: \$20 co-pay

Deductible, Co-Pays, and Out-of-Pocket Dollar Maximums

	New State Health Plan PPO “NSHP – PPO” Benefits		New HMO Plan “NHMO” Benefits
	In-network	Out-of-network	
Deductible	\$400 per member \$800 per family	\$800 per member \$1,600 per family	None
Fixed dollar co-pays	\$20 for office visits, office consultations, urgent care visits, osteopathic manipulations, chiropractic manipulations and medical hearing exams. \$200 for emergency room visits, if not admitted	Not applicable	\$20 for office visits \$200 for emergency room visits, if not admitted
Coinsurance	10% for most services and 20% for private duty nursing and acupuncture	20% for most services. MHSA at 50%	None
Annual out-of-pocket dollar maximums ⁵	\$1,500 per member \$3,000 per family	\$3,000 per member \$6,000 per family	None

⁵ The out-of-pocket limit does not apply to deductibles, fixed dollar co-payments, or private duty nursing co-payments.

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Premium Sharing

	New State Health Plan PPO “NSHP – PPO” Benefits		New HMO Plan “NHMO” Benefits	
	Employee	State	Employee	State
Premium	20%	80%	15% ⁶	85% ⁶

⁶ The State will pay up to 85% of the applicable NHMO total premium, capped at the dollar amount which the State pays for the same coverage code under the NSHP-PPO.

APPENDIX G-2

Effective October 12, 2014 this Appendix applies to all eligible employees regardless of the date of hire and replaces Appendix G and Appendix G-1.

Preventive Services	State Health Plan PPO “SHP – PPO” Benefits		HMO Plan “HMO” Benefits
	In-network	Out-of-network	
Health maintenance exam	Covered 100% 1 per year	Not Covered	Covered 100%
Annual gynecological exam	Covered 100% 1 per calendar year	Not Covered	Covered 100%
Pap smear screening – laboratory services only ¹	Covered 100% 1 per year	Not Covered	Covered 100%
Well-baby and child care	Covered 100%	Not Covered	Covered 100%
Immunizations, annual flu shot & Hepatitis C screening for those at risk	Covered 100%	Not Covered	Covered 100%
Childhood Immunizations	Covered 100% through age 16	Covered 80%	Covered 100%
Fecal occult blood screening ¹	Covered 100%	Not Covered	Covered 100%
Flexible sigmoidoscopy ¹	Covered 100%	Not Covered	Covered 100%
Prostate specific antigen screening ¹	Covered 100% one per year	Not Covered	Covered 100%
Mammography, annual standard film mammography screening (covers digital mammography up to the standard film rate) ¹	Covered 100%	Covered 80% after deductible	Covered 100%

Colonoscopy ¹	Covered 100%	Covered 80% after deductible	Covered 100%
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¹ American Cancer Society guidelines apply

Physician Office Services	State Health Plan PPO “SHP – PPO” Benefits		HMO Plan “HMO” Benefits
	In-network	Out-of-network	
Office visits, consultations and urgent care visits	Covered, \$20 co-pay	Covered 80% after deductible	Covered, \$20 co-pay
Outpatient and home visits	Covered 90% after deductible	Covered 80% after deductible	Covered, \$20 co-pay

Emergency Medical Care	State Health Plan PPO “SHP – PPO” Benefits		HMO Plan “HMO” Benefits
	In-network	Out-of-network	
Hospital emergency room for medical emergency or accidental injury	Covered, \$200 co-pay if not admitted		Covered, \$200 co-pay if not admitted
Ambulance services – medically necessary	Covered, 90% after deductible		Covered, 100% after deductible

Diagnostic Services	State Health Plan PPO “SHP – PPO” Benefits		HMO Plan “HMO” Benefits
	In-network	Out-of-network	
Laboratory and pathology tests	Covered 90% after deductible	Covered 80% after deductible	Covered 100%
Diagnostic tests and x-rays	Covered 90% after deductible	Covered 80% after deductible	Covered 100% after deductible
Radiation therapy	Covered 90% after deductible	Covered 80% after deductible	Covered 100% after deductible

Maternity Services Includes care by a certified nurse midwife (State Health Plan PPO only)	State Health Plan PPO “SHP – PPO” Benefits		HMO Plan “HMO” Benefits
	In-network	Out-of-network	
Prenatal care	Covered 100%	Covered 80% after deductible	Covered 100%
Postnatal care	Covered 90% after deductible	Covered 80% after deductible	Covered, \$20 co-pay
Delivery and nursery care	Covered 90% after deductible	Covered 80% after deductible	Covered 100% after deductible

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Hospital Care	State Health Plan PPO “SHP – PPO” Benefits		HMO Plan “HMO” Benefits
	In-network	Out-of-network	
Semi-private room, inpatient physician care, general nursing care, hospital services and supplies	Covered 90% after deductible, unlimited days	Covered 80% after deductible, unlimited days	Covered 100% after deductible Unlimited days
Inpatient consultations	Covered 90% after deductible	Covered 80% after deductible	Covered 100% after deductible
Chemotherapy	Covered 90% after deductible	Covered 80% after deductible	Covered 100% after deductible

Alternatives to Hospital Care	State Health Plan PPO “SHP – PPO” Benefits		HMO Plan “HMO” Benefits
	In-network	Out-of-network	
Skilled nursing care up to 120 days per confinement	Covered 90% after deductible		Covered 100% after deductible
Hospice care	Covered 100% Limited to the lifetime dollar maximum that is adjusted annually by the State		Covered 100% after deductible
Home health care	Covered 90% after deductible, unlimited visits		Check with your HMO

Surgical Services	State Health Plan PPO “SHP – PPO” Benefits		HMO Plan “HMO” Benefits
	In-network	Out-of-network	
Surgery—includes related surgical services.	Covered 90% after deductible	Covered 80% after deductible	Covered 100% after deductible
Male Voluntary sterilization	Covered 90% after deductible	Covered 80% after deductible	Covered 100% after deductible
Female Voluntary sterilization	Covered 100%	Covered 80% after deductible	Covered 100%

Human Organ and Tissue Transplants	State Health Plan PPO “SHP – PPO” Benefits		HMO Plan “HMO” Benefits
	In-network	Out-of-network	
Liver, heart, lung, pancreas, and other specified organ transplants	Covered 100% In designated facilities only. Up to \$1 million lifetime maximum for each organ transplant		Covered 100% after deductible in designated facilities
Bone marrow—specific criteria apply	Covered 100% after deductible in designated facilities		Covered 100% after deductible in designated facilities
Kidney, cornea, and skin	Covered 90% after deductible in designated facilities	Covered 80% after deductible	Covered 100% after deductible subject to medical criteria

Other Services	State Health Plan PPO “SHP – PPO” Benefits		HMO Plan “HMO” Benefits
	In-network	Out-of-network	
Allergy testing and therapy (non-injection)	Covered 90% after deductible	Covered 80% after deductible	Covered, 100% after deductible.
Allergy injections	Covered 90% after deductible	Covered 80% after deductible	Covered 100%
Acupuncture	Covered 80% after deductible if performed by or under the supervision of a M.D. or D.O.		Check with your HMO
Rabies treatment after initial emergency room visit	Covered 90% after deductible	Covered 80% after deductible	Office visits: \$20 co-pay. Injections: Covered 100%
Autism-Spectrum Disorder Applied Behavioral Analysis (ABA) treatment	Covered 90% after deductible	Covered 80% after deductible	Covered, 100% after deductible
Chiropractic/spinal manipulation	Covered, \$20 co-pay Up to 24 visits per calendar year	Covered 80% after deductible Up to 24 visits per calendar year	Check with your HMO
Durable medical equipment	Covered 100%	Covered 80% of approved amount	Covered, check with your HMO
Prosthetic and orthotic appliances	Covered 100%	Covered 80% of approved amount	Covered, check with your HMO
Private duty nursing	Covered 80% after deductible		Check with your HMO
Wig, wig stand, adhesives	Upon meeting medical conditions, eligible for a lifetime maximum reimbursement of \$300. (Additional wigs covered for children due to growth).		Check with your HMO
Hearing Care Exam	Covered, \$20 co-pay	Covered 80% after deductible	Check with your HMO

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Mental Health/Substance Abuse	State Health Plan PPO “SHP – PPO” Benefits		HMO Plan “HMO” Benefits
	In-network	Out-of-network	
Mental Health Benefits - Inpatient	Covered 100% up to 365 days per year ²	Covered 50% up to 365 days per year	Check with your HMO; Inpatient services subject to deductible.
Mental Health Benefits – Outpatient	As necessary 90% of network rates 10% co-pay	As necessary 50% of network rates	Check with your HMO
Alcohol & Chemical Dependency Benefits – Inpatient	Covered 100% ³ Halfway House 100%	Covered 50% ⁴ Halfway House 50%	Check with your HMO; Inpatient services subject to deductible.
Alcohol & Chemical Dependency Benefits - Outpatient	\$3,500 per calendar year 90% of network rates 10% co-pay ⁴	\$3,500 per calendar year 50% of network rates	Check with your HMO

² Inpatient days may be utilized for partial day hospitalization (PHP) at 2:1 ratio. One inpatient day equals two PHP days.

³ Up to two 28-day admissions per year. There must be at least 60 days between admissions. Inpatient days may be utilized for intensive outpatient treatment (IOP) at 2:1 ratio. One inpatient day equals two IOP days.

⁴ \$3,500 per calendar year limitation pertains to services for chemical dependency only.

Prescription Drugs

Prescription medications for the State Health Plan PPO are carved out and administered by a Pharmacy Benefit Manager (PBM).

Prescriptions filled at a participating pharmacy may only be approved for up to a 34-day supply. Employees can still receive a 90-day supply by mail order.

To check the co-pay for drugs you may be taking, visit the Civil Service Commission Employee Benefits Division website at <http://www.michigan.gov/employeebenefits> and select Benefit Plan Administrators.

The chart below shows the SHP and HMO prescription drug member co-pays:

Generic	Brand Name Preferred	Brand Name Non-Preferred
Retail \$10	Retail \$30	Retail \$60
Mail Order \$20	Mail Order \$60	Mail Order \$120

Outpatient Physical, Speech, and Occupational Therapy Combined maximum of 90 visits per calendar year.	State Health Plan PPO “SHP – PPO” Benefits		HMO Plan “HMO” Benefits
	In-network	Out-of-network	
Outpatient physical, speech and occupational therapy – facility and clinic services	Covered 90% after deductible	Covered 90% after deductible	Covered, \$20 co-pay
Outpatient physical therapy – physician's office	Covered 90% after deductible	Covered 80% after deductible	Covered, \$20 co-pay

Deductible, Co-Pays, and Out-of-Pocket Dollar Maximums	State Health Plan PPO “SHP – PPO” Benefits		HMO Plan “HMO” Benefits
	In-network	Out-of-network	
Deductible ⁵	\$400 per member \$800 per family	\$800 per member \$1,600 per family	\$125 per member \$250 per family
Fixed dollar co-pays	\$20 for office visits, office consultations, urgent care visits, osteopathic manipulations, chiropractic manipulations and medical hearing exams. \$200 for emergency room visits, if not admitted	Not applicable	\$20 for office visits \$200 for emergency room visits, if not admitted
Coinsurance	10% for most services and 20% for private duty nursing and acupuncture	20% for most services. MHSA at 50%	None
Annual out-of-pocket dollar maximums ⁶	\$2,000 per member and \$4,000 per family	\$3,000 per member \$6,000 per family	\$2,000 per member and \$4,000 per family

⁵ Deductible amounts for the SHP – PPO are effective January 1, 2015 and renew annually on a calendar year basis. Deductible amounts for the HMOs are effective October 12, 2014 and renew annually each October with the start of the new plan year.

⁶ Beginning October 12, 2014, in-network deductibles, in-network fixed dollar co-payments and in-network co-insurance all apply toward the out-of-pocket annual limit. In addition, in HMOs, prescription drug co-payments also apply toward the annual out-of-pocket limit. Beginning with the October 2015 plan year, prescription drug co-payments in the SHP PPO also apply to the annual out-of-pocket limit.

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Premium Sharing	State Health Plan PPO “SHP – PPO” Benefits		HMO Plan “HMO” Benefits	
	Employee	State	Employee	State
Premium	20%	80%	15%	85% ⁷

⁷ The State will pay up to 85% of the applicable HMO total premium, capped at the dollar amount which the State pays for the same coverage code under the SHP-PPO.

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